MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

09244

Reg. Dist. No. 2-52

1. PLACE OF DEATH:
County: Queen Anne
City or town: Centreville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 55 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Queen Anne
City or town: Centreville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Susan Ann Anthony

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: ✓
6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): May 31 - 1861

8. AGE:

Years	Months	Days	If less than one day
84	3	21	...hrs. ...min.

9. Birthplace: Q. A. Co
(Town, county, and state)
10. Usual occupation: Dressmaker
11. Industry or business:
FATHER 12. Name: Benjamin Anthony
13. Birthplace: Queen Anne Co
MOTHER 14. Maiden name: Susan Pinkfines
15. Birthplace: Do not know.
16. Informant: Mrs. Bessie Green
Address: Centreville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 23-45 (month) (day) (year)
Cemetery or crematory: Chesterfield
Location: Centreville, Md
18. Funeral director: Barton Bros.
Address: Centreville, Md
19. Sept. 22 - 1945 (Date rec'd by registrar) Elsie Armstrong Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-21 1945, at 4:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...1945, to 9-21 1945
and that I last saw h... alive on 9-21 1945

	DURATION
Immediate cause of death: Pneumonia	
Due to: Hypostatic	
Due to:	
Other conditions: Senility	

(Include pregneney within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. S. McPherson M. D. or other
Address: Centreville Date signed: 9/22/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

09245

Reg. Dist. No. 251

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Queen Anne's
City or town: Near Millington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred: Palmer Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New Jersey County:
City or town: R.F.D. Millington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Pallabora New Jersey
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth Baker

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Samuel R.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 9 1867

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
77	10	4		

9. Birthplace: Paulsboro, Gloucester Co., N.J.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Benjamin Stevenson
13. Birthplace: Penna.

MOTHER
14. Maiden name: Mary A. Carr
15. Birthplace: Penna.

16. Informant: Isaac Allen
Address: Smyrna Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 16 1945 (month) (day) (year)
Cemetery or crematory: Elegator
Location: Clarksboro N.J.

18. Funeral director: Edward Lee Lane
Address: Millington Md.

19. Sept. 15 1945 (Date rec'd by registrar) Edgar Lane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 13 1945 at 9 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10 1945 to Sept. 13 1945
and that I last saw him alive on Sept. 11 1945

Immediate cause of death	DURATION
Uremia	3 days
Due to: Chr. Interstitial Nephritis	Several years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Merritt Morris M. D. or other
Address: Millington Md. Date signed: Sept 14/45

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-3)

09246

CERTIFICATE OF DEATH

Reg. Diat. No. 254

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Queen Anne

City or town: Queenstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Queen Anne

City or town: Queenstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Conyer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: William Conyer

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Mar. 1 - 1908

8. AGE:

Years	Months	Days	If less than one day
37	6	6	...hrs. ...min.

9. Birthplace: Grasonville, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Oyster Shucker

FATHER 12. Name: Alfa Lawson Tilghman

13. Birthplace: Baltimore, Md

MOTHER 14. Maiden name: Lizzie Coleman

15. Birthplace: Grasonville, Md

16. Informant: Hazel Conyer

Address: Queenstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 10 1945 (month) (day) (year)

Cemetery or crematory: Robinson A.M.E. Cemetery

Location: Grasonville, Md.

18. Funeral director: John D. Williams

Address: Easton, Md.

19. 9-10-1945 (Date rec'd by registrar) H. M. Aldridge for Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 7 te 1945 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sep 7 1945, to Sep 7 1945 and that I last saw h... alive on Sep 5 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Hypertension	6 mos
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. H. E. Snyder M. D. or other

Address: Grasonville Date signed: 9/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

CERTIFICATE OF DEATH

★ 09247 Reg. Dist. No. 2S1

1. PLACE OF DEATH:
County: Queen Annes
City or town: Millington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, Institution, or street address where death occurred:
Rabbins Nursing Home
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Md. County: Kent
City or town: Millington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary V. Davis

3.(b) Social Security Number: none ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

6.(b) Name of husband or wife: Neal Davis
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 29, 1870

8. AGE: Years	Months	Days	If less than one day
74 ~~75~~	8	10	..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: Thomas Henry
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary King
15. Birthplace: Md.

16. Informant: Benjamin Walls
Address: 217 Sutton Rd. Ardmore, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 10 1945 (month) (day) (year)
Cemetery or crematory: Dulaney
Location: Mt. Lake Md.
18. Funeral director: Edward E. Glover
Address: Millington Md.

19. Sept. 9 1945 (Date rec'd by registrar) E. E. Lane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 8 1945 at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 7th 1945 to Sept. 8th 1945
and that I last saw h... alive on Sept. 3rd 1945

Immediate cause of death	DURATION
Mitral Stenosis	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: G. L. Cleland M.D.
M. D. or other
Address: Millington Md. Date signed: Sept. 9th 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-D)

09248

CERTIFICATE OF DEATH

Reg. Dist. No. 254

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Queen Annes
City or town: Queenstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Annes
City or town: Queenstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Elizabeth Draper

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Nathan Draper
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): October 5 - 1873

8. AGE: Years	Months	Days	If less than one day
71	11	12	..... hrs. ..... min.

9. Birthplace: Kent Co. Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: William James Pinder
13. Birthplace: Queen Annes Co

MOTHER
14. Maiden name: Deborah Catherine Carr
15. Birthplace: Queen Annes Co Md

16. Informant: Mr Nathan Draper
Address: Queenstown Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 20-45 (month) (day) (year)
Cemetery or crematory: Chesterfield
Location: Centreville Maryland

18. Funeral director: Barton Bros
Address: Centreville, Maryland.

19. 9-19-1945 (Date rec'd by registrar) Helen M Ledidge Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 17 1945, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 1943, to 9-17 1945
and that I last saw h.. alive on 9-15 1945

Immediate cause of death	DURATION
Paralysis	
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. B. McPherson M. D. or other
Address: Centreville Date signed: 9/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-a)

CERTIFICATE OF DEATH

09249

Reg. Diat. No. 253

1. PLACE OF DEATH:
County: Queen Anne
City or town: Gouldtown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Queen Anne
City or town: Near Queenstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Wm Gould

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 24-1880

8. AGE:

Years	Months	Days	If less than one day
65	2	26	..... hrs. ..... min.

9. Birthplace: Queen Anne Co. Md
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business

FATHER
12. Name: Benjamin Gould
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary Ellen March
15. Birthplace: Md.

18. Informant: Tom Gould (Brother)
Address: Centreville Md. R.F.D

17. Burial, cremation, or removal. Which? Burial Date thereof Sept 23-45 (month) (day) (year)
Cemetery or crematory: Gouldtown
Location: Gouldtown Md
18. Funeral director: Edgar L Lane
Address: Church Hill Md

19. Sept. 22-1945 (Date rec'd by registrar) Elsie Armstrong Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19- 1945 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16- 1945 to Sept 19- 1945 and that I last saw him alive on Sept 16- 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to	
Due to	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. Henry Fisher M. D. or other
Address: Centreville Md Date signed: 9/25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17a)

CERTIFICATE OF DEATH

09250

Reg. Dist. No. 251

1. PLACE OF DEATH:
County: Queen Anne
City or town: Price
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Queen Anne
City or town: Price
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lillian V Thynson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 26 - 1945

8. AGE: Years: 5 | Months: 5 | Days: 14 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Price Queen Anne Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Alfred Gaines
13. Birthplace: Centreville Md.

MOTHER
14. Maiden name: Martha Thynson
15. Birthplace: Hayden Md.

16. Informant: Martha Thynson
Address: Price Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 13-1945 (month) (day) (year)
Cemetery or crematory: Hope
Location: Hope Md.

18. Funeral director: Edgar L. Lane
Address: Church Hill Md.

19. Sept. 13 1945 (Date rec'd by registrar) Edgar L. Lane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 12 1945, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 11 1945 to Sept 12 1945 and that I last saw h.. alive on Sept 12 1945

Immediate cause of death	DURATION
Decomposition + Infection	6 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Dr. Wm. Richmond M. D. or other
Address: Chestertown Date signed Sept 13 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9252)

CERTIFICATE OF DEATH

09251

Reg. Dist. No. 252

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Queen Anne
City or town: Centreville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Anne
City or town: Centreville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Lizzie Harrington Knotts

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James T. Knotts
6.(c) If alive, give age: 72 years
7. Birth date of deceased (mo., day, yr.): Oct 26 - 1874

8. AGE:	Years	Months	Days	If less than one day
	70	10	22	...hrs. ...min.

9. Birthplace: Delaware (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: William Harrington
13. Birthplace: Delaware

MOTHER
14. Maiden name: Susan Stafford
15. Birthplace: Maryland

16. Informant: James T. Knotts
Address: Centreville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 19-45 (month) (day) (year)
Cemetery or crematory: Sudlersville
Location: Sudlersville - Md
18. Funeral director: Barton Bros
Address: Centreville, Md
19. Sept. 17 - 1945 (Date rec'd by registrar) Elsie Armstrong Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 17, 1945, at 2 20/60 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15 1945, to 9-17 1945, and that I last saw h. M. alive on 9-16 1945

Immediate cause of death	DURATION
Chronic Valvular disease of the heart	
Due to Hypertension	
Due to Paralysis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ✓ Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. S. McPherson M. D. or other
Address: Centreville Md Date signed: 9/17/45

19252

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 253

(M)

1. PLACE OF DEATH:
County: Queen Anne's
City or town: Stevensville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Q. A.
City or town: Near Stevensville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Virginia Roe

3.(b) Social Security Number:

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: John A. Roe
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 6 - 1879
8. AGE: Years: 66 Months: Days: If less than one day: hrs. min.
9. Birthplace: Q. A. Co. (Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business: Home
FATHER 12. Name: [illegible] Hess
13. Birthplace: Q. A. Co.
MOTHER 14. Maiden name: Annie Freel
15. Birthplace: Q. A. Co.
16. Informant: Mrs. Matilda Thomas
Address: Stevensville
17. Burial, cremation, or removal. Which?: Burial Date thereof: Sept 15-45 (month) (day) (year)
Cemetery or crematory: Stevensville
Location: Stevensville, Md.
18. Funeral director: Frank Thomas
Address: Stevensville
19. (Date rec'd by registrar): 9/15 19 45 Registrar: F. C. Thomas

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13 1945 at 5 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 1945 to Sept. 13 1945 and that I last saw h[illegible] alive on Sept. 12 1945

Immediate cause of death	DURATION
Sclerosis of coronary arteries	1 month
Due to: Arterio sclerosis	3 yrs
Due to:	
Other conditions: Cerebral Thrombosis	1943

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Theodor Sattelmaier M.D.
M. D. or other
Address: Stevensville Date signed: 9/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89a)

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:
County: Queen Anne's
City or town: Rural Chesterton Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County:
City or town: West Chester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Edith C Scatt

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: John C Scatt
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 18 1875

8. AGE: Years: 70 | Months: 0 | Days: 20 | If less than one day: hrs. min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: Robert Cummins
13. Birthplace: Delaware

MOTHER — 14. Maiden name: Laura Johnson
15. Birthplace: Delaware

16. Informant: John C Scatt
Address: 322 S. Matlack St. West Chester

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 11 (month) (day) 6a (year) 45

Cemetery or crematory: Cherry Hill
Location: Cherry Hill Md.

18. Funeral director: Edward Kellum
Address: Millington Md.

19. Sept. 9 1945 (Date rec'd by registrar) E. L. Lane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 7 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6a 1945, to Sept 7a 1945, and that I last saw h alive on Sept 6a 1945

Immediate cause of death	DURATION
(a) Pleurisy	2 days
Due to: (b) Hypertension	2 yrs
Due to: (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G. L. Copeland M.D.
M. D. or other
Address: Millington Md. Date signed: Sept 8 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

9254

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

★ Reg. Dist. No. 252

1. PLACE OF DEATH:

County: Queen Anne

City or town: ~~Easton~~ Centreville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Yr.

Hospital, Institution, or street address where death occurred: R.F.D. #1

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Queen Anne

City or town: Centreville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D. #1

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: JOSEPH HASTON WOOD

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife: Florence Jane Wood

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): January 6, 1897

8. AGE: Years 48 Months 8 Days 12 If less than one day ____ hrs. ____ min.

9. Birthplace: Caroline Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: J. Fred Wood

FATHER — 13. Birthplace: Caroline Co. Md.

MOTHER — 14. Maiden name: Ella Callahan

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Florence Wood

Address: Centreville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 21, 1945 (month) (day) (year)

Cemetery or crematory: Chesterfield

Location: Centreville, Md.

18. Funeral director: L. Ellis Clark

Address: Easton, Md.

19. 9-21-1945 (Date rec'd by registrar) Elsie Armstrong Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 18 1945 at 6 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1— 1945 to Sept. 18 1945 and that I last saw h wife alive on Sept 18. 1945

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. Henry Fisher M. D. or other

Address: Centreville Md. Date signed: 9/20-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15